Division of Licensing and Protection
103 South Main Street
Waterbury, VT 05671-2306
http://www.dail.vermont.gov
Voice/TTY (802) 871-3317
To Report Adult Abuse: (800) 564-1612
Fax (802) 871-3318

August 3, 2015

Ms. Mary Belanger, Manager
St Joseph's Residential Care Home
243 North Prospect Street
Burlington, VT 05401-1609

Dear Ms. Belanger:

Enclosed is a copy of your acceptable plans of correction for the survey conducted on **July 6, 2015.** Please post this document in a prominent place in your facility.

We may follow-up to verify that substantial compliance has been achieved and maintained. If we find that your facility has failed to achieve or maintain substantial compliance, remedies may be imposed.

Sincerely,

Pamela M. Cota, RN
Licensing Chief

PRINTED: 07/13/2015
FORM APPROVED

Division of Licensing and Protection

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0155	A. BUILDING: _____ B. WING _____	C 07/06/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST JOSEPH'S RESIDENTIAL CARE HOME	243 NORTH PROSPECT STREET BURLINGTON, VT 05401

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
R100	Initial Comments: An unannounced on-site complaint investigation was conducted on 7/6/15 by the Division of Licensing and Protection. The following regulatory violations were identified.	R100		
R126 SS=G	V. RESIDENT CARE AND HOME SERVICES 5.5 General Care 5.5.a Upon a resident's admission to a residential care home, necessary services shall be provided or arranged to meet the resident's personal, psychosocial, nursing and medical care needs. This REQUIREMENT is not met as evidenced by: Based on staff interview and record review the home failed to meet the identified safety care needs for 1 of 2 residents reviewed. (Resident #1). Findings include: Per record review and despite the fact that Resident #1, who was admitted to the home on 6/1/15, had exhibited elopement behaviors in the early morning hours of 6/4/15 indicating a high risk safety concern, the home failed to implement an adequate plan to assure the ongoing safety of the resident who eloped again 4 days later and sustained significant injury. A nurse's note, at 6:45 AM on 6/4/15, indicated that, despite the alarm system on all exit doors, Resident #1 had been found in the parking lot, outside the home at approximately 4:40 AM that morning, after s/he had rung the doorbell attempting to enter the home. The note stated that the resident was very	R126		

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R126	Continued From page 1 confused at the time and reported to staff that s/he had been trying to get into cars. Another nurse's note, 4 days later on 6/8/15 at 6:55 AM, stated that Resident #1 was observed sleeping in his/her room at 1:15 AM that morning and noted to be missing from his/her room at approximately 3:15 AM. The note further stated that all door alarms had been on but not heard by anyone. The resident was subsequently found off the home's property by police, was transferred to the ED (Emergency Department) with significant injuries and died approximately 2 - 3 weeks later. During interview both the home's Administrator and DNS (Director of Nursing Services) acknowledged the home's awareness that the door alarm system had failed to alert staff of Resident #1's exit from the home in the early morning hours of 6/4/15. The DNS stated that although the door alarm security system had failed to alert staff to the resident's exit the system had not been replaced at that time. S/he indicated that the only additional plan implemented to assure a safe environment for Resident #1 was for staff to conduct safety checks on an hourly basis, however, despite this the resident was still able to exit the home, once again, without staff knowledge. The Administrator stated that, despite the second elopement and subsequent injury to Resident #1 on 6/8/15, a new security system had not been installed until recently and it was first up and running on the afternoon of survey on 7/6/15. *This is a repeat deficiency	R126	As of July 6, 2015, as witnessed by State Survey Nurse, ST. Joseph's Residential Care Home has installed a door alarm system. This system automatically arms at 9:00pm and disarms at 5:00 am. If any door in the building is breached between those hours, the following sequence of events occurs: 1. The keypads by the front door and by the kitchen/smokers doors; the alarm monitoring company is alerted automatically. 2. The alarm company calls the Nurse/Med Tech's Cell phone number. If they answer- they inform the nurse which door has been breached and asks for a code to deactivate the alarm 3. If they do not answer the LNA/Caregiver is called on their cell phone 4. If no answer the alarm company calls the house phone, 5. If no answer, then 911 is called and 6. The Administrator is called Once staff is notified, they immediately investigate to see who breached the door. The call process should not take more than 2-3 minutes at most. The staff is told the specific door that was breached and is able to do a search in the specific location quickly. If resident is not located after an external and internal check, 911 is called immediately.	
R266 SS=G	IX. PHYSICAL PLANT	R266	R126 PCC accepted 8/3/15 Bhaverd 1PM	

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R266	Continued From page 2 9.1 Environment 9.1.a The home must provide and maintain a safe, functional, sanitary, homelike and comfortable environment. This REQUIREMENT is not met as evidenced by: Based on observation, staff interviews and record review the home failed to assure a consistently safe environment for one at risk resident. (Resident #1). Findings include: Per record review and despite the fact that Resident #1, who was admitted to the home on 6/1/15, had exhibited elopement behaviors in the early morning hours of 6/4/15, the home failed to implement an adequate plan to assure the ongoing safety of the resident who eloped again 4 days later and sustained significant self injury. A nurse's note, at 6:45 AM on 6/4/15, indicated that, despite the alarm system on all exit doors, Resident #1 had been found in the parking lot, outside the home at approximately 4:40 AM that morning, after s/he had rung the doorbell attempting to enter the home. The note stated that the resident was very confused at the time and reported to staff that s/he had been trying to get into cars. Another nurse's note, 4 days later on 6/8/15 at 6:55 AM, stated that Resident #1 was observed sleeping in his/her room at 1:15 AM that morning and noted to be missing from his/her room at approximately 3:15 AM. The note further stated that all door alarms had been on but not heard by anyone. The resident was subsequently found off the home's property by police, was transferred to the ED (Emergency Department) with significant injuries and expired approximately 2 - 3 weeks later.	R266		

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R266	Continued From page 3 During interview both the home's Administrator and DNS (Director of Nursing Services) acknowledged the home's awareness that the door alarm system had failed to alert staff of Resident #1's exit from the home in the early morning hours of 6/4/15. The DNS stated that although the door alarm security system had failed to alert staff to the resident's exit the system had not been replaced at that time. S/he indicated that the only additional plan implemented to assure a safe environment for Resident #1 was for staff to conduct safety checks on an hourly basis, however, despite this the resident was still able to exit the home, once again, without staff knowledge. The Administrator stated that, despite the second elopement and subsequent injury to Resident #1 on 6/8/15, a new security system had not been installed until recently and it was first up and running on the afternoon of survey on 7/6/15. *This is a repeat deficiency	R266	As of July 6, 2015, as witnessed by State Survey Nurse, ST. Joseph's Residential Care Home has installed a door alarm system. This system automatically arms at 9:00pm and disarms at 5:00 am. If any door in the building is breached between those hours, the following sequence of events occurs: 1. The keypads by the front door and by the kitchen/smokers doors; the alarm monitoring company is alerted automatically. 2. The alarm company calls the Nurse/Med Tech's Cell phone number. If they answer- they inform the nurse which door has been breached and asks for a code to deactivate the alarm 3. If they do not answer the LNA/Caregiver is called on their cell phone 4. If no answer the alarm company calls the house phone, 5. If no answer, then 911 is called and 6. The Administrator is called Once staff is notified, they immediately investigate to see who breached the door. The call process should not take more than 2-3 minutes at most. The staff is told the specific door that was breached and is able to do a search in the specific location quickly. If resident is not located after an external and internal check, 911 is called immediately. This system was installed by Life Safety Systems. They also provide weekly testing of the system. There is also a green check mark on both the panels to indicate that the system is activated. Staff was trained by either the installer or the DNS. New staff are trained as part of their new hire orientation. Attached are the instructions that are posted as a reference for all nursing staff. R266 POC accepted 8/3/15 BitweRN/PMC	

Door Alarm System procedure
July 6, 2015

All exterior doors are alarmed and connected to our Home Security provider; sometimes referred to as Central Station.

This system will automatically arm (turn on) at 9:00pm and disarm (turn off) at 5:00am.

There are two keypads in the building; one at the front door, the other at the smoker's door.

These are the ONLY doors that evening and night shift can use to enter and exit the building.

When entering the building after 9:30pm, staff members must disarm the system to prevent the alarm from going off.

To do this:

Enter through the front door or smokers

1. Go immediately to the key pad.

-One is located on the wall inside the interior door at the smoker's entrance.

-The other is located on the wall inside the door at the top of the stairs at the front door.

2. Enter your code and press enter
   -currently everyone's code is 243.

   This will disarm the alarm. The alarm will reset itself in 30 seconds.
   This code is confidential and should not be shared with any residents.

   To exit the building after 9:30pm and before 5:00am

   1. Go to either the front door or the smoker's door.
   2. Enter the code and press enter. Leave the building immediately to prevent the alarm from going off.
   3. The alarm will reset in 30 seconds.

If a resident leaves the building between the hours of 9:30pm and 5:00am, the system will alarm. The panels at the front door and smokers doors will alarm. It is **unlikely** you will hear those alarms. (If you do, disarm the system using the code and call the alarm company to avoid a false alarm) This will send a signal to home security/central station. Within 1 minute of receiving the call, they will do the following:

1. Call the med tech's cell phone-if not answered
2. Call the care givers cell phone-if not answered
3. Call the house phone-if not answered
4. Call 911- to be sent out **and**

5. Call Mary Belanger to notify of situation.

When/if the call is answered by a staff member, they will be told that the alarm is going off and what door was triggered. This will enable staff members to immediately go to that door and locate the resident that left the building.

The doors are referred to and labeled as follows:

1. Front door
2. Smoker's door
3. Parking lot door
4. Bus parking door
5. Cemetery door
6. Dining room door
7. Delivery/ramp door